

Commentary

Artificial Insemination by Donor (AID) and the Use of Surrogate Mothers Social and Psychological Impact

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Today families are being created by such procedures as test tube fertilization, artificial insemination and surrogate parenting. In addition to traditional couples, moreover, single persons, gay couples and others are seeking to form family units. In the eagerness to produce an offspring there is often little thought given to the needs or the feelings of the child so produced. There is a need for sociomedical data as well as a more open approach in these situations.

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At present we are seeing the emergence of various substitutes for the traditional conception and incorporation of children into the family. These include artificial insemination by donor (AID) and surrogate mothers. Reviews of these practices in both the scientific literature¹ and lay publications (*Newsweek*, December 6, 1982, p 30) discuss logistical and legal problems involved but, except for a few articles, they ignore a crucial issue: the child so conceived.

In this report we will consider the psychosocial and ethical impact of these two procedures particularly as they relate to the offspring so produced and offer some suggestions for the professionals who may find themselves involved, one way or another, with these practices.

AID Births

Conception by artificial insemination has been practiced for a long time although, until recently, it was used largely by married couples where the husband was infertile. Great care was taken to insure the anonymity of the donor to all but the physician performing the procedure. Professional donors, paid a fee for their services, have been used for multiple insemination using fresh or frozen sperm and, formerly, sometimes employing mixed semen pools or mixing the husband's and donor's semen at the time of insemination to insure further anonymity.

Now single women and lesbian couples are demanding the right to bear children by AID and are even circumventing the doctors and are, in some cases, inseminating each other with such appliances as turkey basters using sperm provided by male friends.

Surrogate Parenting

While AID in its conventional sense has been practiced for some time, the emergence of surrogate parenting is quite new. Here an infertile couple contracts with another woman who agrees, usually for a substantial fee, to be inseminated with the semen of the husband of the couple, to bear the child and turn over the baby at the time of birth to the contracting couple, who then adopt the child.

Organizations and foundations devoted to surrogate parenting are now appearing in this country, often managed by physicians or attorneys. One such organization in Southern California has published a directory or "catalogue" complete with pictures and vital statistics of women who are offering themselves as surrogates.

Background

AID and surrogate parenting have in common the satisfying of the desires of couples or individual persons to have a child which they could not or did not choose to have by conventional means. In so doing they

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are considering themselves to the exclusion of the interests of the child so produced.

A survey in 1979¹ reported 379 practitioners of AID who collectively accounted for 3,576 births in 1977. Almost 10% of the practitioners had used the procedure to fertilize single women. Sandler² has a good discussion of the practice and recommends rather strict criteria for its use. He rejects single women, lesbians and couples with a great disparity of age. He accepts paraplegic husbands only if they have a reasonable life expectancy. He does not use frozen semen; his donors are all volunteer fertile husbands of consenting previously infertile wives who have produced at least one normal child. Donors must not be related to the couple and, except for reasonable traveling expenses, are paid no fee.

When it comes to the question of telling the child how he was conceived Sandler says,

In adoption there is a history which would presumably exist, but in the case of AID total anonymity must be preserved at all costs since this promise is given to the donor in the first place and cannot be broken. Therefore . . . if a child is told of his origins he might possibly request such information, which will almost always not be available in AID . . . There is another reason for not telling the child. When adoption takes place, all the relatives and acquaintances are aware of the fact . . . in AID, however, the child is the product of the mother's body. Telling a child that it was conceived by AID immediately exposes the husband's sterility.

Sandler does relent, however, when a parent carries a sex-linked recessive gene lest the child believe he or she is a carrier.

Discussing AID from its legal aspects, Annas³ reports that there are an estimated 250,000 children conceived by AID in the United States at the rate of 6,000 to 10,000 a year. The procedure has been shrouded in secrecy that is primarily justified by a fear of potential legal consequences should the fact of AID be discovered. Most of the commentary on AID has concentrated on theoretic legal problems without paying attention to real psychological problems. Annas says

current rationale for servicing the infertile couple, the lesbian couple, the single woman all rest primarily on one's definition of the best interests of the couple or the prospective parent and not on the best interest of the child.³

Since in the survey virtually all respondents paid for this service, Annas prefers the term "sperm vendor" to "sperm donor." He disagrees with Sandler in the matter of telling the children, feeling that, as with the case of adopted persons, if the AID children learn that they are products of AID, they will want to be able to identify their genetic father. He notes, as we record here, that AID children do learn the truth. The only thing that all 15 states with legislation on AID agree on is that the children should be legitimized. Annas proposes registering all AID children in a court-sealed record that would remain sealed until the death of the donor or until the donor waived his right to privacy, or to use only frozen sperm of deceased donors; albeit to date, there have been no suits against any donor by any child.

In our work of helping and counseling adult adoptees at the Post Adoption Center for Education and Re-

search (PACER), Palo Alto, California, we have also been contacted by persons who have discovered that they were conceived through AID. Their frustration and disappointments have been great since there is usually little or no information available from which to trace a genetic background.

Reports of Cases

CASE 1. The woman was 31 years old when she found that she was an AID child. Learning at 31 that her father was a sperm donor she felt resentment against her parents and blames an unhappy childhood on their inability to cope with the AID. "Living the big lie warped and poisoned the relationship beyond repair." After her mother died, the woman's father finally told her she was an AID child. "You have to understand that to my father the fact that my mother was impregnated by another man was an ugly secret. His infertility was an ugly secret. It was something to be ashamed of." Her feelings about her discovery are portrayed in her comments about the semen donor:

I wanted to know how he could have sold what was the essence of my life for \$25 to a total stranger, then walk away without a second thought. I wanted to know why he didn't have the maturity to think about me . . . why couldn't he connect the semen to the human being it would create?

CASE 2. This woman was 33 years old in 1981 when she wrote the following:

I have been denied knowledge of my birth father because of artificial insemination in 1948. My parents divorced shortly afterward and I grew up basically without a father. I wonder how many (hundreds?) of brothers and sisters I have? I wonder if my children will ever run into their aunts and uncles and cousins unbeknownst to me? I have so many unmet questions and needs. I wish there could be some publicity about this and encourage donors to come forward and register—if their children wish to know of their heredity. Also, I wish some contact with doctors who perform such services could be made. I'd like a third party to contact mother's doctor, Dr A, and see what information could be had for me—even if a name wasn't provided. I wish my name could be provided to my father. Dr A will be at least 75 now—what becomes of his records when he dies? Any help you can offer would be appreciated. My mother is willing for me to make such inquiries, although I was told of the circumstances of my birth against her wishes when I was 11.

A few years ago an obstetrical resident was delivering a child from a mother who had been artificially inseminated. Imagine his surprise when, having himself been a semen donor, he delivered an infant with a birthmark identical to his own. Except in such unusual instances, a sperm donor usually has no knowledge of or attachment to his offspring. Not so in the case of a surrogate mother.

The woman who agrees to become a surrogate mother is compared with the birth mother who places her unplanned child for adoption. Though there are some similarities, there are also great differences. In one case the pregnancy is intentional; the other is unintentional. In both situations there will be a profound sense of separation and loss requiring sensitive support and therapy to come to terms with the loss and associated grief. When the pregnancy is unintended we

know that effective counseling requires that the mother retain control over the decision-making process about the alternatives for her child and herself. The extent to which she can assume responsibility for her decision is the key to her later emotional well-being.

A surrogate mother faces the same issues except she must deal with the added fact that her pregnancy was intended. She must decide in advance and accept responsibility for a chain of events that results in her child being permanently separated from her. We know that the experience of conception, gestation and birth has a profound effect on all mothers. Further, for the surrogate mother, pregnancy does not come from sexual contact from a relationship with a partner; it comes from a contractual agreement to bear a child for a couple. The experience of gestation and birth is similar, however, so that even a woman who starts out wanting to do something generous for a couple may find herself wanting to keep the baby.⁴ As much as she may try, it is difficult for a surrogate mother to anticipate the short-term and long-term feelings that will arise. Although a surrogate mother may begin her pregnancy convinced that she will remain detached, she is unlikely to remain detached as giving birth becomes a reality and she faces separation from the child. Family members of the surrogate mother (her parents, his parents, other children in the family) all must cope with the decision to carry a child to term and relinquish that child for a sum of money specified in the contract.

Does a surrogate mother make these decisions on her own or does she consult with family members? Will their sense of permanency in the family be otherwise impaired? What relationship, if any, might they expect for the half brother or half sister once their sibling is grown and emancipated? These are just some of the complex issues facing the surrogate mother and her family.

Issues for an Adopting Couple

We know from our work with adoptive couples and foster parents that creating a family through adoption can be both rewarding and difficult. It takes special sensitivity and parenting skills. Successful adoptive parents acknowledge that their family is formed in a different way.⁵ Those who deny this difference tend to create families in which the child's growth and development and relationships within the family become problematic. Those who acknowledge this difference tend to create relationships with their adopted children based on mutual understanding and sharing of the experience of separation and loss. All of this requires a commitment to openness and a sensitivity to the growing child's need to know basic facts about his or her conception, birth and genetic ancestry.

A couple who turns to the surrogate procedure faces these same issues. They must cope with the question of the circumstances of the new child's entry into the family, explaining them to other children in the family and to members of their extended family and friends.

The couple may be tempted to pretend that the child is their natural child. They may also be tempted to explain to the child and others that the child was simply adopted. There is a growing body of research documenting the negative effects of family secrets and their special power in the family system.⁶

Two illustrations may help in understanding the issue.

(1) In a recent surrogate contract in Michigan, the mother gave birth to a defective child. The adopting couple refused to accept the child. Blood tests proved the contention of the adopting father that he was not the biological father of the child and, in fact, the surrogate's husband was found to be the real father.

(2) In 1982 a childless couple contacted a surrogate-provider group in an eastern state. During the course of their negotiations the attorney and the physician of the group split apart. Each had found and offered the couple a surrogate who was willing to carry a child for them. The couple decided to accept both surrogates, whereupon the first gave birth to a single child and the second one had twins. Now the couple has three children of the same age. They are quite open about the fact that these children had surrogate mothers, have collected full background information and pictures from both and plan to be completely open and frank with their children as they grow up to inform them of the nature of their births.

Issues for the Child

"Is the desire to have a child at whatever price more important than the self-esteem of the person you create?" (*New York Times Magazine*, July 20, 1980, p 14).

It was largely through the efforts of adult adoptees that the various professionals and the public were made aware that this group had been denied certain basic rights and had been reduced to an inferior status by virtue of the secrecy involved in most of the adoption processes. Now we are seeing the same sort of situation arise in the case of AID and surrogate births, only the problem is even more complex.⁷⁻¹⁰

"They need never know," one might say. But they frequently do find out in spite of the best attempts at secrecy. When they do find out they feel cheated and betrayed. And when they then try to find out the true story of their birth they often embark on a path marked by frustration and many unanswerable questions. The effect on the personality and behavior of an AID or surrogate child can be profound and lifelong.

We do not mean to imply that knowing the facts relating to the birth will insure a normal emotional development. Quite the contrary. Persons conceived by these means will always have some problems of adjustment and acceptance of their status but we do feel that they are better off knowing the truth from the outset.

Recommendations

Our first concern is that all professionals become aware of the issues involved—issues of priority, of

values, of intentions, of consequences—not just now but in the years ahead. To this end we suggest that the basic question in each case be *Is it in the best interest of the child?*

Noting that genetic knowledge was deficient in the screening of AID donors, we would ask for genetic consultation for each couple who requests AID or surrogate birth, and for every sperm donor and surrogate mother.

We feel that a complete medical history, family history and genetic background should be obtained from every AID donor and from every surrogate mother. This record should be kept by someone who can make it available to the offspring when he or she reaches maturity or when such information should be necessary. In addition, a mechanism should be available for updating this medical information during the child's early years should something significant develop.

Finally, we would make a plea for more openness in all these situations. Better that a husband accept his infertility and admit it than that the child be raised under the delusion that he is the biological father. The

same recognition should be given to the surrogate mother. Recognizing her as the biological parent should in no way detract from the bonding and attachment to the psychological parents who are raising the child.

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